Mississippi State Department of Health

Bureau Emergency Medical Services

Medical First Responder
Course Approval/Request Form

Teaching Affiliate: _____ Date: _____

Address: _____ Phone Number: _____

City, State, Zip: _____ E-mail: _____

Instructor: _____ Phone Number: _____

Address: _____ Fax Number: _____

City, State, Zip: _____ E-mail: _____

Assistant Instructor: _____ Phone Number: _____

Course Location: _____

Address: _____ City, State, Zip: _____

First Class Date: _____ Last Class Date: _____

Class Start Time: _____ Class End Time: _____

Total Classroom Hours: _____ Days of Class: _____

Teaching Affiliate Signature: _____

Instructor Signature: _____

BEMS Approval Signature: _____ **Course Number:** _____

Please attach a copy of the class Syllabus

Note: The Medical First Responder Curriculum must meet all requirements of the BEMS.

(Please submit to the BEMS 14 days prior to the first day of class)